

#4512

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

16702

FILED MAY 20 1944 18

Primary Registration District No.

1003

Registrar's No.

4308

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... St. Louis, Missouri.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... 7 days
 (Specify whether
 In this community.....
 years, months or days)

3. (a) PRINT
FULL NAME

SOPHIA ROMANS

3. (b) If veteran,

name war..... none

3. (c) Social Security

No..... none

4. Sex..... female 5. Color or race..... white 6. (a) Single, widowed, married,
 divorced..... married
 6. (b) Name of husband or wife..... Wm. Romans 6. (c) Age of husband or wife if
 alive..... 66 years
 7. Birth date of deceased..... Sept. 19 1886
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 7 18 hr. min.

9. Birthplace..... St. Louis Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Rudolph F. Glaessner13. Birthplace..... St. Louis Mo.
 (City, town, or county) (State or foreign country)14. Maiden name..... Dorothy Braun15. Birthplace..... St. Louis Mo.
 (City, town, or county) (State or foreign country)16. (a) Informant..... William Romans(b) Address..... 2707 1/2 Madison St.17. (a) Burial (b) Date thereof..... 5-10-44
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation..... St. Matthews Cem.18. (a) Signature of funeral director..... Hy. Leidner U. Co.(b) Address..... 2223 St. Louis Ave.19. (a) MAY 10 1944 (b) J. J. Bueck
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County.....
 (c) City or town..... St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No..... 2707 1/2 Madison St.
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... May day..... 7th
 year..... 1944 hour..... 6 minute..... 00 P. M.

21. I hereby certify that I attended the deceased from..... April 26th
, 19..... 44 to..... May 7th, 19..... 44
 that I last saw h..... er alive on..... May 7th, 19..... 44
 and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings:

Of operations..... noneOf autopsy..... none

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
 (b) Date of occurrence.....
 (c) Where did injury occur?..... (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work.....

(Specify type of place)

(e) Means of injury.....

23. Signature..... J. J. Bueck (b) J. J. Bueck
 Address..... 1515 Lafayette Date signed..... 5/8/44

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

John P. Buchholz

Licensed Embalmer No. *1674*

P. O. Address *2423 St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.